STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495253	A. BUILDING _____ B. WING _____	C 10/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF NORFOLK	1401 HALSTEAD AVENUE NORFOLK, VA 23502

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/11/16 through 10/14/16. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care Requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 112 at the time of the survey. The survey sample consisted of 20 current resident reviews (Residents #1 through 20) and 7 closed record reviews (Resident #21 through 27)	F 000		
F 156 SS=D	NOTICE OF RIGHTS, RULES, SERVICES, CHARGES CFR(s): 483.10(b)(5) - (10), 483.10(b)(1) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those	F 156		11/18/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/02/2016

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other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a

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F 156	Continued From page 2 complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Baaed on staff interview, clinical record review and facility document review, the facility staff failed to provide a written Notice of Medicare Provider Non-Coverage for services to allow for an appeal for 3 of 27 residents in the survey sample, Resident #21, 22 and 23. The findings included: 1. Resident #21 was admitted to the facility on 7/22/16 for skilled therapy services following a stroke requiring hospitalization. The resident's primary payer source was Medicare Part A. The admission MDS (Minimum Data Set) with an assessment reference date of 7/29/16 coded the resident as scoring a 12 out of a possible 15 on	F 156	F-156 1. No correction to be made for residents # 21, 22, and 23. Residents are no longer at facility. 2. All resident utilizing Medicare benefits are at risk for this issue. 3. All resident using Medicare benefits are discussed every Wednesday to track progress in therapy and anyone coming off therapy. A log has been created to track residents last covered day, date notice issued, and date signed and acknowledged. Notice of Medicare Provider Non-Coverage will be issued by Social Service Director or designee. Copy given to resident/responsible party for signature, copy filed.	

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F 156	Continued From page 3 the Brief Interview for Mental Status, this score indicated the resident's cognition was moderately impaired. The resident received speech, occupational and physical therapy during this assessment period. Resident #21 was discharged home on 9/2/16. According to the Rehab Director on 10/14/16, the resident's last day (termination of treatment) of rehab services was 9/1/16. Review of the closed record failed to evidence the facility staff provided written information to the resident pertaining to Medicare Non-Coverage services to allow the resident the choice to appeal. The Social Services Director (SSD) was interviewed on 10/13/16. He stated he was newly hired as of 8/1/16. The SSD stated he had not been informed that he was responsible for providing the written notifications of Medicare Non-Coverage to residents being discharged from skilled services until the end of September 2016. Review of the facility's policy (untitled) with a revision date of 9/2016 read, in part: The facility will assure all residents received timely and appropriate notification of Medicare non-coverage for services in accordance with State and Federal guidelines. Procedure: Notices will be issued whenever a "triggering event" occurs. (A triggering even is defined by Medicare as one of three changes to services: initiation, reduction, or termination.) Medicare defines circumstances which constitute the three triggering events for Notice Delivery as: 3. Termination of Treatment: Termination is the	F 156	4. Logs checked weekly and discussed monthly at QA by Administrator or designee to ensure compliance. 5. Compliance by 11/18/16.	

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discontinuation of certain items or services. Notice must be issued prior to, but no later than 2 days before termination of such items or services. If the beneficiary wishes to continue receiving non-covered items or services upon receiving the Notice, he or she must indicate such on the Notice stating that he or she wants to receive the services and agrees to be financially responsible if Medicare does not pay.
B. Traditional Medicare Part A-stay:
1. For residents who will be discharged the first calendar day following their last Medicare covered day, the Social Worker, or Designee, will notify the Resident/Authorized Representative when the resident is approaching the end of coverage, but no later than 2 days prior to the last covered Medicare Part A day, by issuing the Notice of Medicare Provider Non-coverage CMS-10123. This Notice advises the Resident/Authorized Representative that covered care is ending and of their immediate appeal rights.

The above finding was shared with the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Regional Reimbursement Specialist, during the pre-exit meeting conducted on 10/14/16 at 12:15 p.m.

2. Resident #22 was admitted to the facility on 8/4/16 for skilled therapy services following a stroke requiring hospitalization. The resident's primary payer source was Medicare Part A.

The admission MDS (Minimum Data Set) with an assessment reference date of 8/11/16 coded the resident as scoring a 14 out of a possible 15 on the Brief Interview for Mental Status, this score

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indicated the resident's cognition was intact. The resident received speech, occupational and physical therapy during this assessment period.

Resident #22 was discharged home on 8/24/16. According to the Rehab Director on 10/14/16, the resident's last day of rehab services was 8/23/16.

Review of the closed record failed to evidence the facility staff provided written information to the resident pertaining to Medicare Non-Coverage services to allow the resident the choice to appeal.

The Social Services Director (SSD) was interviewed on 10/13/16. He stated he was newly hired as of 8/1/16. The SSD stated he had not been informed that he was responsible for providing the written notifications of Medicare Non-Coverage to residents being discharged from skilled services until the end of September 2016.

The above finding was shared with the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Regional Reimbursement Specialist, during the pre-exit meeting conducted on 10/14/16 at 12:15 p.m.

3. Resident #23 was admitted to the facility on 5/31/16 for skilled therapy services following a stroke requiring hospitalization. The resident's primary payer source was Medicare Part A.

The admission MDS (Minimum Data Set) with an assessment reference date of 6/7/16 coded the resident as scoring a 15 out of a possible 15 on

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F 156	Continued From page 6 the Brief Interview for Mental Status, this score indicated the resident's cognition was intact. The resident received speech, occupational and physical therapy during this assessment period. Resident #23 was discharged home on 7/15/16. According to the Rehab Director on 10/14/16, the resident's last day of rehab services was 7/14/16. Review of the closed record failed to evidence the facility staff provided written information to the resident pertaining to Medicare Non-Coverage services to allow the resident the choice to appeal. The Social Services Director (SSD) was interviewed on 10/13/16. He stated he was newly hired as of 8/1/16. The SSD stated he had not been informed that he was responsible for providing the written notifications of Medicare Non-Coverage to residents being discharged from skilled services until the end of September 2016. The above finding was shared with the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Regional Reimbursement Specialist, during the pre-exit meeting conducted on 10/14/16 at 12:15 p.m.	F 156		
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.13(c)(1)(ii)-(iii), (c)(2) - (4) The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment	F 225		11/18/16

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F 225	Continued From page 7 of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to investigate an injury of unknown origin for 1 of 27 resident (Resident #25) and the facility failed to report a facility reportable incidence to the Office of Licensure and Certification.	F 225	F-225 1. No correction to be made for resident #25. Resident is no longer at the facility. 2. All residents are at risk for this issue. 3. All departments to be in-serviced by Administrator or designee on reporting	

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F 225	Continued From page 8 1. For Resident #25, the facility staff failed to provide evidence (residents, staff, and family interviews) that an injury of unknown origin was thoroughly investigated. 2. The facility staff failed to notify the Office of Licensure and Certification within 24 hours of a Facility Reportable Incident involving Utility Failure that occurred on 10/9/16. The findings included: Resident #25 was originally admitted to the facility on 11/5/13 and readmitted on 12/15/15. Resident #25 expired in the facility on 3/31/16. Diagnoses for Resident #25 included but are not limited to vascular dementia (loss of cognitive abilities), delirium (state of mental confusion), manic depression, palliative care (comfort measures only), brain injury, and fracture of the right lower leg. Resident #25's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 10/02/15 coded Resident #25 with memory problems with a BIMS of 9 (Brief Interview for Mental Status- assessment tool) indicating moderate cognitive impairment. In addition, the Minimum Data Set coded Resident #25 requiring extensive assistance on staff for Activities of Daily Living care. A clinical record review was conducted on 10/13/16 and 10/14/16. According to the Event Investigation (Incident) Report Assessment dated 11/12/15, Resident #25 was identified to have bruising on the right ankle and a x-ray scheduled. Also, the Physician and Representative were both	F 225	injuries of unknown origin or suspected abuse immediately. Any allegations will be properly investigated with all involved staff and witnesses interviewed as deemed necessary. Documentation of investigation will be retained on file by Administrator or Director of Nursing. All instances that require reporting to the Office of Licensure and Certification will be reported within 24hrs. 4. All incidents reported to the OLC will be discussed monthly at QA to ensure proper reporting and investigation. 5. Compliance by 11/18/16.	

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notified on 11/12/15 at 6:37 and 6:38 (neither a.m. nor p.m. was documented.)

The Weekly Skin Check Assessment dated 11/12/15 documented, "Bruise observed to outer aspect of right ankle" signed by LPN #7. A clinical nursing note dated 11/12/15 at 07:37 (a.m.) written by LPN #7 documented, "Bi weekly skin assessment performed. Small bruise observed to right outer aspect of ankle. Ankle warm to touch. +3 pitting edema present to foot. Foot palpated and flexed with no discomfort noted to resident. RP (responsible party) and MD notified with new order for x-ray received. Oncoming nurse aware."

Patient Report from the x-ray company dated 11/12/15 documented service and signed by MD at 08:00:57 [8:00 a.m.]. A written note on the x-ray report documented to "ER (emergency room) for evaluation."

Another clinical noted dated 11/12/15 at 14:59 (1:46 p.m..) documented, "Telephone report to Hospital ER [Emergency Room] report to RN at ER."

Administrative record ADT (Admissions, Discharges, and Transfers) was presented by the facility Administrator on 10/14/16 at approximately 11:50 a.m. documented Resident #25 leaving the facility on 11/12/15 at 15:15 [3:15 p.m.] for the hospital. Resident #25 returned to the facility from the hospital on 11/12/15 at 21:38 [9:38 p.m.].

A final clinical note written by the charge RN #1 dated 11/12/15 at 21:38 p.m. documented, "Received [Resident #25] via medical transport to RM [room #]..."

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The clinical review provided details regarding assessment and process to assist resident with injury. No evidence was presented regarding investigation of the incident within the clinical record review.

According to a Facility Reported Incident Report (FRI) sent into the Office of Licensure and Certification there was an incident dated 11/12/15 where Resident #25 was noted with bruise on the right ankle, an injury of unknown origin. A follow-up FRI Investigation note dated 11/18/15 documented included but not limited to, "Staff interviews conducted with no definitive explanation for fracture. Resident's [family] was also interviewed. [Family] propels resident throughout the facility daily in his w/c [wheelchair]. Resident's [family] denies any incidents while propelling resident around facility...It is possible that another resident that self-propels w/c could have bumped into resident's foot/ankle causing the fracture. Resident had dementia and is unable to tell staff what happened." The conclusion from the Investigation Note documented, "Fracture does not appear to be from any form of deliberate harm or abuse."

A call was placed to LPN #7 and a message left but no response was made during the survey. Charge RN (Registered Nurse) #1 no longer works at the facility. In an interview on 10/14/16 at 11:30 a.m. the new Director of Nursing assisted with documentation review but could not speak to the incident as she was not working at the facility during the incident date 11/12/15.

According to the Administrator on 10/14/16 at 11:00 a.m., He was aware of the FRI but would

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have to check into the investigation the former DON conducted. The administrator produced a Staff Statement for the Event Reporting sheet dated 11/12/15. One staff member wrote the following statement, "To whom it may concern, as I was giving [Resident #25] a shower I noticed that his right ankle was swollen. As I notified the nurse she stated that an x-ray was going to [be] done." On 10/14/16 at 11:20 a.m. the Administrator stated, "I can't find any interviews regarding an investigation." No resident, staff, or family interviews were presented by the facility during the survey.

According to the Abuse and Neglect Policy provided by the facility with a revised date of 2/26/01 under Policy: It is the belief of [the facility] that every resident has the right to be free from mistreatment and neglect. This policy seeks to prevent [abuse]. In order to safeguard against abuse, [The facility] has developed policies that focus on seven components:screening, training, prevention, identification, investigation, protection, and reporting/response." Under the heading titled, "Investigation" this policy documented, "The Administrator and Director of Nursing will work together during the initial investigation to determine course of action." There is no evidence that the facility staff thoroughly investigated Resident #25's injury of unknown origin. There was only a statement on the FRI that an investigation was conducted.

An additional undated policy was presented by the facility titled, "Virginia: Reporting Abuse and Injuries of Unknown Origin". This documented, "When the facility concluded conditions are true [three conditions were outlined], the facility must conduct an internal investigation and report the

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incident to OLC (Office of Licensure and Certification)"

The facility administration was informed of the findings during a briefing on 10/14/16 at approximately 12:20 p.m. The facility did not present any further information about the findings.

2. The facility staff failed to notify the Office of Licensure and Certification within 24 hours of a Facility Reportable Incident involving Utility Failure that occurred on 10/9/16.

The findings included:

During the initial tour of the facility on 10/12/16 several residents reported to surveyors that on Sunday 10/9/16 the facility was without electrical power.

On 10/11/16 at approximately 7:45 p.m. an interview was conducted with the Administrator, Maintenance Director, Dietary Manager, and the Director of Nursing where they were asked about the electrical power outage on 10/9/16. The Maintenance Director stated, "On Saturday 10/8/16 around 9:23 p.m. the power went off because of the storm and the generator kicked on. But the generator only ran for about 20 minutes then cut off. I called (Name) Diesel and came and manually reset the air damper switch on the generator. The generator ran from approximately 11:00 p.m. on 10/8/16 until Sunday afternoon 10/9/16 around 12:25 p.m. when the generator cut off again. I called (Name) Diesel at 12:26 p.m. and made them aware and they told me they would be leaving Dare County North Carolina with a backup generator. We were

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without power in the building from 12:25 p.m. until 5:45 p.m. on Sunday 10/9/16. At 5:45 p.m. the power came back on at the same time (Name) Diesel was pulling in with the backup generator. (Name) Diesel determined that the voltage regulator had burn up in our old generator, it is 23 years old."

On 10/12/16 at approximately 9:45 a.m. the Administrator was asked if a Facility Reportable Incident had been filed with the Office of Licensure and Certification regarding the facilities electrical power outage on 10/9/16. The Administrator stated, "No, I didn't."

On 10/12/16 at 10:45 a.m. the Administrator presented the surveyor with a copy of the Facility Reported Incident regarding the electrical power outage and generator usage from 10/8/16-10/9/16 showing it was faxed to the Office of Licensure and Certification on 10/12/16 at 10:37 a.m. The Office of Licensure and Certification was notified approximately 70 hours after the full loss of electrical power on 10/9/16.

On 10/13/16 at 4:00 p.m. an interview was conducted with the Administrator. The Administrator was asked why he did not send a Facility Reported Incident Regarding the power outage to the Office of Licensure and Certification on Monday 10/11/16. The Administrator stated, "We were so busy and overwhelmed with the storm I just didn't think about it. We were just trying to get everything back in order."

The facility Operational Core Systems Section 1 Administrative Practices 2.0 titled "Virginia: Reporting Abuse, Neglect, Misappropriation of Resident Personnel Property or injuries of

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F 225	Continued From page 14 unknown origin" documented in part, as follows: Procedure: Office of Licensure and Certification: 1) Allegations must be reported to the Office of Licensure and Certification (OLC) when the Facility has reasonable cause to believe that: *The Facility has sufficient evidence, or another regulatory authority could obtain evidence, to show the Alleged incident occurred: and *The incident meets, or could meet, the definition of mistreatment, abuse, neglect, or misappropriation. On the Virginia Department of Heath Office of Licensure and Certification Facility Reported Incident (FRI) document under Incident type: Utility failure is listed as reportable. On 10/14/16 at 12:15 p.m. a pre-exit conference was held with the Administrator, the Director of Nursing, and the Reimbursement Specialist where the above information was shared. No further information was provided prior to exit.	F 225		
F 253 SS=D	HOUSEKEEPING & MAINTENANCE SERVICES CFR(s): 483.15(h)(2) The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility	F 253	F-253	11/18/16

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F 253	Continued From page 15 document review, the facility staff failed to provide housekeeping and maintenance services necessary to ensure resident care equipment and common areas were maintained in a sanitary manner and in good repair. 1. The facility staff failed to maintain an IV (intravenous) Pole and wheelchair straps in a clean and sanitary condition and to ensure the foot rest of a wheelchair was in good repair for Resident #17. 2. The facility staff failed to provide effective housekeeping and maintenance services in common areas used by the residents. The findings included: 1. Resident #17 was admitted to the facility on 8/8/16. Diagnoses for Resident #17 included but not limited to Cerebral Palsy (a group of disorders that affect a person's ability to move and maintain balance and posture), dysphagia (difficulty in swallowing) and muscle weakness. The Resident #17's comprehensive Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 8/15/16 coded Resident #17 as not having the ability to complete the Brief Interview for Mental Status. Resident #17 was also coded as "Activity did not occur" for walking in room and walking in corridor. Resident #17 is confined to a wheelchair when out of bed. Resident #17 was coded "Total dependence" for eating and receives feeding through a feeding tube. On 10/13/16 at 12:52 pm, Resident #17 was sitting in his wheelchair in the Sunroom with other residents. Resident #17's wheelchair was	F 253	1. Resident #17□s wheelchair immediately repaired and IV pole cleaned. Chairs in dining room and day room were cleaned. Maintenance Director to repair broken tiles and hole in wall in spa room. Chipped paint on walls Unit2 to be repaired/painted. Light fixtures to be cleaned. Wallpaper room 506 repaired or removed. 2. All residents are at risk for these issues. 3. Housekeeping and nursing staff to be in-serviced by the Director of Housekeeping on cleaning of wheelchairs and IV poles. Housekeeping and Nursing staff inserviced on use of Maintenance Request form to submit when problems are identified. Maintenance staff to be in-serviced by Administrator or designee on repairing/replacing broken or damaged equipment and who to notify if discovered to be in need of cleaning or repairing. Maintenance and Housekeeping Supervisors to do daily audits of equipment to ensure cleanliness and safe operating condition of resident equipment. 4. Daily audits of facility furniture and resident equipment for three months then random weekly to include follow through by housekeeping and maintenance by the Administrator or designee. Results will be shared monthly at QA. 5. Compliance by 11/18/16.	

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observed to have a tear approximately 4x4x2 inch on one corner of the foot rest with the interior foam cushion sticking out. The other corner of the foot rest had an approximately 4 inch tear. The chair straps were also observed to be very soiled with dried feeding formula. The entire IV pole used for the feeding pump was also very soiled with feeding formula and dust.

On 10/13/16 at 1:00 pm, an interview was conducted with LPN #2 who went to see Resident #17's wheelchair and IV pole. When asked what her observations were, LPN#2 stated, "IV pole has some feeding drip. I will go get something to clean it. It should be wiped down when it's dirty". Regarding the wheelchair and wheelchair straps, LPN #2 stated, "There's a tear on footrest. The straps are dirty. He vomits sometimes." When asked what LPN #2 would do if found wheelchair in this condition, LPN #2 stated, "Order another footrest. Throw straps in the wash".

On 10/13/16 at 1:05 pm, an interview was conducted with LPN #3 (Nurse Manager) who looked at Resident #17's IV Pole and wheelchair. When asked what her observations were regarding the IV pole, LPN #3 stated, "It's dirty. Should wipe it down if drips on it". When asked regarding the condition of the wheelchair, LPN #3 stated, "It has rip on footrest. The family brought in this chair, so will report and ask family to find out through (agency)".

LPN #2 went ahead and cleaned the IV pole with a disinfectant wipes.

On 10/13/16 at 1:10 pm, an interview was conducted with the DON and when asked regarding the facility procedure for wheelchairs in

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need of repair, the DON stated, "Put a request or let maintenance know and if maintenance not able to repair, call the manufacturer". When asked regarding her expectations from staff for resident care equipment in need of cleaning, the DON stated, "Should have been wiped down".

On 10/13/16 at 1:40 pm, the Director of Maintenance provided a copy of the facility "Wheelchair Wash Schedule" and Resident #17's wheelchair was scheduled for washing on 10/4/16. The "Date Completed" column on the document was blank.

On 10/13/16 at 3:10 pm, an interview was conducted with the Director of Environmental Services who was asked regarding the facility policy and procedure for cleaning resident care equipment, such as an IV pole, and stated, "The Environmental Services and Nursing staff are responsible for cleaning IV poles. The CNAs clean it before it gets heavy".

On 10/14/16 at 9:00 am, an interview was conducted with the Director of Maintenance and was asked regarding the facility procedure for wheelchair repair and stated, "I wash them according to schedule and if there are issues, I fix them right away. For wheelchair cushions, the Director of Rehab takes care of it".

On 10/14/16 at 9:05 am, an interview was conducted with the Director of Rehab and was asked regarding the facility procedure for wheelchair cushions in need of repair and stated, "If brought to my attention, we look in the shed and if we don't have it, we order through (name of a company).

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On 10/14/16 at 9:45 am, together with CNA #1 and the Director of Environmental Services, checked on Resident #17's wheelchair and observed that the tears on the foot rest have been repaired using a black plastic tape. The straps were still soiled. CNA #1 removed the soiled straps to wash and stated, "I wash them when soiled".

The Administrator and the DON were made aware of these findings on 10/14/16 at 12:15 pm, no further information was provided.

2. The facility staff failed to provide effective housekeeping and maintenance services in common areas used by the residents.

A general observation of the facility was conducted on 10/13/16 at 1:35 p.m. The following was observed.
1. In the main dining room were 10 wooden chairs with fabric seats. Each of these 10 chair seats were visibly soiled and in need of cleaning.
2. On unit 1 the day room wicker rocking chair vinyl cushions were visibly worn out and soiled.
3. The unit 1 men's spa was observed to have multiple broken and missing tiles.
4. One of the light fixtures inside the unit 1 female spa had multiple dead insects.
5. The unit 2 female spa had multiple cracked tiles. A hole approximately a quarter size where the toilet paper roll holder once was, was filled in with toilet paper.
6. Multiple chipped painted walls were observed up and down the main hallway on unit 2.
7. Torn wall paper behind the head of bed in resident room 506.

On 10/13/16 at 3:15 p.m., the Housekeeping

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F 253	Continued From page 19 Director (HD) was interviewed. The above housekeeping findings was shared. The HD stated, "Since I have been here (8/27/16) they haven't been cleaned." He further stated he was made aware of the dining room chairs needing to be cleaned by a dietary service worker approximately a month ago. He stated it was on his "to do" list. On 10/13/16 at 3:25 p.m., the Maintenance Director (MD) was interviewed. The above maintenance findings was shared. The MD stated, "(name of company) bought this building approximately 3-4 months ago...we are scheduled for a remodel...as soon as a resident is discharged we try to "turn" the room (paint, wallpaper)...the tiles were scheduled to be replaced this Monday morning." The above finding was shared with the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Regional Reimbursement Specialist, during the pre-exit meeting conducted on 10/14/16 at 12:15 p.m.	F 253		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.20(d)(3), 483.10(k)(2) The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending	F 280		11/18/16

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F 280	Continued From page 20 physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility documentation review, the facility staff failed to invite residents to participate in care plan meetings for 1 of 27 residents (Resident # 19) in the survey sample. Resident # 19 was not invited to participate in her care plan meeting. The findings included: Resident # 19 was admitted to the facility on 08/01/2016. Diagnoses for Resident # 19 included but not limited to Personality Disorder, Muscle Weakness, Bipolar Disorder, Episode of Manic Severe with Psychosis, Type II Diabetes. Resident # 19 Quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 08/08/2016, coded resident with a BIMS score of 15, indicating no memory impairment. On 10/13/16 at 1:15 p.m., during a group meeting with the residents, this surveyor asked the group if everyone is being invited to attend their care	F 280	F-280 1. Interdisciplinary Care Plan was scheduled for Res #19. She and Responsible Party were invited to attend. 2. All residents are at risk for this issue. 3. Log created to track date of care conference, date family and resident notified, and how they were notified. Resident/RP will receive written invitation. May receive additional notification verbally by phone or in person. Copy of written invitation/notice will be kept on file by Social Service. Care conference summary verifies meeting held and who was in attendance. 4. Logs will be checked weekly and discussed monthly at QA meeting by Administrator or designee to ensure compliance. 5. Compliance by 11/18/16.	

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plan meetings, Resident # 19 stated, "I did not attend my care plan meeting nor was I invited to attend."

Care Plan Meeting: The nursing home staff will get your health information and review your health condition to prepare your care plan. You (if you're able), your family (with your permission), or someone acting on your behalf has the right to take part in planning your care with the nursing home staff (<https://www.medicare.gov/what-medicare-covers/part-a/care-plan-in-nursing-home.html>).

On 10/13/16 at 2:05 p.m., an interview was conducted with the MDS Coordinator. This surveyor asked the MDS Coordinator who invites residents to attend their care plan meeting, she stated, "The Social Worker." The MDS Coordinator stated, "I will give the Social Worker (SW) the date for the care plan meeting, I do attend the care plan meeting but I do not inform the residents when their care plan meeting occurs." When asked if Resident # 19 attended her care plan meeting and she replied, ' I don't think so" but you need to check with the SW to make sure ."

On 10/13/16 at 2:25 p.m., during an interview with the SW, this surveyor asked who is responsible for inviting residents to attend their care plan meeting, he replied, "I'm responsible for inviting resident or the responsible party to attend the care plan meeting." This surveyor asked the SW was Resident # 19, invited to attend her care plan meeting, he replied, "I'm not sure." The SW was not able to provide written documentation that the resident was invited to attended her care

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F 280	Continued From page 22 plan meeting. On 10/13/16 at 3:40 p.m., the facility was not able to produce any documentation that Resident # 19 was invited to attend her care plan meeting, the SW then replied, " I don't know how I missed it." On 10/14/16 at 10:25 a.m., during an interview with the SW, this surveyor asked the SW the process for informing family and residents of their care plan meetings, he replied "I will call the family and let the residents know in person." This surveyor asked Social Worker, do you ever deliver or send out letters to inform them of care plan meetings, he replied, "No, I only call." On 10/14/16 at 10:50 a.m., Director of Nursing (DON) was informed that Resident # 19 was not invited to attend her care plan meeting that was held on 08/17/16. The facility Administrator, DON, Assistant DON and corporate nurse were informed of the findings during a briefing on 10/14/16 at approximately 12:15 p.m. The facility did not present any future information. The facility policy: Care Plan date revised August 2015. Under Section M: "The facility designee is responsible for delivering to each resident who is scheduled for conference an invitation to attend the meeting. The letter of requested participation (original) is presented to the resident at least (5) days prior to the date of the conference. A designated time of meeting is given to each resident (A copy of the letter is maintained for reference)."	F 280		
F 322	NG TREATMENT/SERVICES - RESTORE	F 322		11/18/16

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F 322 SS=D	Continued From page 23 EATING SKILLS CFR(s): 483.25(g)(2) Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to ensure appropriate treatment and services for tube feeding for 2 of 27 residents in the survey sample, Residents #17 and #18. 1. The facility staff failed to check placement of a feeding tube prior to a medication administration on Resident #17. 2. The facility staff failed to check placement of a feeding tube prior to administering a bolus tube	F 322	F322- 1. LPN #□s 1 and 2 were immediately re-educated on the policy and procedure related to checking for placement of the g-tube prior to the administration of medication and feeding. Residents # 17 and 18 g-tubes were immediately checked for placement and found to be present and in the correct place. 2. All residents with G-tubes have the potential to be affected	

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F 322	Continued From page 24 feeding on Resident #18. The findings included: 1. Resident #17 was admitted to the facility on 8/8/16. Diagnoses for Resident #17 included but not limited to Cerebral Palsy (a group of disorders that affect a person's ability to move and maintain balance and posture), dysphagia (difficulty in swallowing) and muscle weakness. The Resident #17's comprehensive Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 8/15/16 coded Resident #17 as not having the ability to complete the Brief Interview for Mental Status. Resident #17 was coded "Total dependence" for eating and receives feeding through a feeding tube. During the medication administration observation on 10/12/16 at 4:00 pm, LPN #1 failed to check placement of the feeding tube prior to medication administration for Resident #17. On 10/12/16 at 6:05 pm, an interview was conducted with LPN #1 and was asked the procedure for medication administration through a feeding tube. LPN #2 stated the procedure but failed to mention checking for feeding tube placement prior to medication administration. When asked if she had checked for feeding tube placement, LPN #2 stated, "No, I did not do it today. I did when I first came here in June." When asked for reason for not checking placement, LPN #2 stated, "No reason." On 10/12/16 at 6:10 pm, the corporate nurse provided a copy of the facility policy and procedure , "IIA9 - General Guidelines for Administering Medication Via Enteral Tube",	F 322	3. Licensed nursing staff will receive in-service on the policy and procedure related to medication administration and feeding via g-tube by DON or designee. 4. Random observations of g-tube med pass will be observed 2x week x 5 weeks, weekly x 1 month, and monthly x 3months by the Unit Managers or designee. Audit results will be shared in QA meeting monthly. 5. Compliance by 11/18/16	

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dated May 2016 (Source: Legacy Consultant Pharmacy). Checking of placement for feeding tube was not addressed in the policy.

On 10/13/16 at 9:15 am, the facility provided a copy of Resident #17's Care Plan (initiated on 8/15/16) and it stated, "Focus: Resident is at increased nutritional risk related to gastric tube use; Goal #2: Will be free of complications related to presence of feeding tube daily; Intervention #1: "Check tube placement prior to med/tube feeding administration."

On 10/13/16 at 10:50 am, an interview was conducted with the Director of Nursing (DON) and was asked about her expectations when nurses administer medications through a feeding tube. The DON explained the procedure and stated, "... Check placement of the feeding tube prior to medication administration..."

On 10/13/16 at 3:30 pm, an interview was conducted with the corporate nurse and the DON regarding available resources for professional standards of clinical practice for nurses in the facility and the corporate nurse stated that the company uses a nursing textbook. The corporate nurse was asked regarding tube feeding procedure and stated, ".... Check placement of feeding tube...". A copy of the "Tube Feeding Procedure" (Source: Lippincott's Nursing Procedures, 6th edition) was provided by the DON and it stated, "For gastric feeding, check placement of the feeding tube to be sure it hasn't slipped out since the last feeding".

On 10/13/16 at approximately 4:00 pm, the Staff Development Coordinator provided a copy of the most current training on tube feeding and was

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presented during a "Medication Pass Skills Fair" on 6/9/16. It included a topic on Enteral Medications and included a statement, "Prior to medication administration, check tube for placement". LPN #1 had not attended this training.

The Administrator and the DON were made aware of these findings on 10/14/16 at 12:15 pm, no further information was provided.

2. Resident #18 was admitted to the facility on 11/11/15. Diagnoses for Resident #18 included but not limited to Cerebral Palsy (a group of disorders that affect a person's ability to move and maintain balance and posture) and blindness. The Resident #18's comprehensive Minimum Data Set (an assessment protocol) with an assessment reference date of 10/4/16, coded Resident #18 as not having the ability to complete the Brief Interview for Mental Status. Resident #18 was coded "Total dependence" for eating and receives feeding through a feeding tube.

During the medication administration observation on 10/12/16 at 4:00 pm, LPN #1 failed to check placement of the feeding tube prior to providing bolus feeding for Resident #18.

On 10/12/16 at 6:05 pm, an interview was conducted with LPN #1 and was asked the procedure for bolus feeding through a feeding tube. LPN #2 stated the procedure but failed to mention checking for feeding tube placement prior to administration of bolus feeding. When asked if she had checked for feeding tube placement, LPN #2 stated, "No, I did not do it today. I did when I first came here in June". When asked for reason for not checking placement,

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LPN #2 stated, "No reason".

According to the Physician Order Summary Report, Resident #18 receives, "Enteral Feed Order every 4 hours Jevity 1.5 cal. 200 ml bolus via PEG Tube". A PEG (Percutaneous Endoscopic Gastrostomy) tube is a tube passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate.

On 10/13/16 at 9:30 am, the Staff Development Coordinator provided a copy of Resident #18 Care Plan (initiated on 4/27/16) and it stated, "Focus: Feeding Tube related to Cerebral Palsy; Goal: Will experience no complications; Intervention #1: Check tube placement per protocol".

A copy of the facility policy and procedure, "Bolus Feeding for NG Tube or G Tube", revision date of October 2015, included a procedure that stated, "To confirm placement of tube in the stomach: A) Attach a syringe to end of tube and place stethoscope over left quadrant of resident's abdomen. Instill 20 cc of air into the tube and listen for swooshing sound in stomach. B) Aspirate stomach contents by attaching syringe to end of tube and gently pulling back on plunger. Open clamp and aspirate the tube to ascertain position or submerge distal end of tube in water and observe for air bubbles, to be sure tube is in stomach".

On 10/13/16 at 10:50 am, an interview was conducted with the Director of Nursing (DON) who was asked about her expectations when nurses administer bolus feeding through a feeding tube. The DON explained the procedure

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F 322	Continued From page 28 and stated, "... Check placement of the feeding tube prior to bolus feeding...." On 10/13/16 at 3:30 pm, an interview was conducted with the corporate nurse and the DON regarding available resources for professional standards of clinical practice for nurses in the facility; the corporate nurse stated that the company uses a nursing textbook. The corporate nurse was asked regarding tube feeding procedure and stated, ".... Check placement of feeding tube...". A copy of the "Tube Feeding Procedure" (Source: Lippincott's Nursing Procedures, 6th edition) was provided by the DON and it stated, "For gastric feeding, check placement of the feeding tube to be sure it hasn't slipped out since the last feeding". On 10/13/16 at approximately 4:00 pm, the Staff Development Coordinator provided a copy of the most current training on tube feeding which was presented during a "Medication Pass Skills Fair" on 6/9/16. It included a topic on Enteral Medications and included a statement, "Prior to medication administration, check tube for placement". LPN #1 had not attended this training. The Administrator and the DON were made aware of these findings on 10/14/16 at 12:15 pm, no further information was provided.	F 322		
F 425 SS=D	PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH CFR(s): 483.60(a),(b) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 425		11/18/16

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F 425	Continued From page 29 §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review the facility staff failed to ensure expired medications were disposed of and not stored alongside other drugs, on 1 of 2 medication rooms. The findings included: A medication room inspection on unit 2 was conducted on 10/13/16 at 12:00 p.m. Accompanying this inspector was licensed practical nurse #6 (LPN). Stored inside the medication refrigerator and along side other medications were two expired multi-dose vials of lorazepam (an anti-anxiety drug). One of the vials was opened; the manufacturers expiration date was 6/1/16. The other vials manufacturers expiration date was 10/1/16. The LPN stated the	F 425	F425- 1. Unit manager on unit 2 and LPN staff immediately re-educated on policy and procedure related to disposal of expired medication. Expired medication was immediately disposed of per facility policy and procedure. 2. Any resident ordered Lorazepam IM or medications stored in the refrigerator has the potential to be affected 3. Licensed nursing staff will be inserviced by the DON or designee on monitoring of all medications for expiration dates.	

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F 425	Continued From page 30 nurse using the drug should check for the expiration date prior to preparation of the drug. The unit 2 nurse manager was interviewed. She stated the pharmacy technician checks the medication refrigerators stored drugs once a month. The unit manager stated these two vials would be handed to the Director of Nursing for disposal. The pharmacy policy titled IIA3: Vials and Ampules of Injectable Medications, effective date 5/2016 read, in part: Policy- Vials and ampules of injectable medications are used in accordance with the manufacturer's recommendations or the provider pharmacy's. directions for storage, use, and disposal. B. EXPIRATION DATES: Unopened vials expire on the manufacturer's expiration date. Opening a vial triggers a shortened expiration date that is unique for that period. The above finding was shared with the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Regional Reimbursement Specialist, during the pre-exit meeting conducted on 10/14/16 at 12:15 p.m.	F 425	4. Refrigerated medication will be observed for expiration date by unit managers weekly and observed on risk rounds twice weekly x 5 weeks by DON or designee for expiration dates. Audit results will be shared in monthly QA meeting. 5. Compliance by 11/18/16.	
F 431 SS=D	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.60(b), (d), (e) The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all	F 431		11/18/16

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F 431	Continued From page 31 controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility document review the facility staff failed to label multi-dose vials of injectable medications once opened, on 2 of 2 medications rooms. The findings included: 1. A medication room inspection on unit 1 was conducted on 10/13/16 at 11:45 a.m.	F 431	F431- 1. Unit managers on units 1 and 2 and nursing staff immediately re-educated on policy and procedure related to dating multi dose vial medications. Unlabeled multi-dose vial medication was immediately disposed of per facility policy. 2. All residents have the potential to be	

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F 431	Continued From page 32 Accompanying this inspector was licensed practical nurse #5. Stored inside the medication refrigerator alongside other drugs was an opened multi-dose vial of PPD (Tuberculin Purified Protein Derivative). The vial did not have an open date. The nurse was asked how long the PPD was good for once opened, her response was, "I'm not sure". When asked if the vial should be dated once opened, she stated, "Yes". The nurse left the medication room, consulted with the staff development coordinator, returned and stated the PPD open vial was good for 30 days. 2. A medication room inspection on unit 2 was conducted on 10/13/16 at 12:00 p.m. Accompanying this inspector was licensed practical nurse #6. Stored inside the medication refrigerator inside a plastic bag were multiple unopened multi-dose vials of lorazepam (an anti-anxiety drug). One of the vials was opened and not dated. The nurse stated it is the responsibility of the nurse opening the vial to date it. The pharmacy policy titled IIA3: Vials and Ampules of Injectable Medications, effective date 5/2016 read, in part: Policy- Vials and ampules of injectable medications are used in accordance with the manufacturer's recommendations or the provider pharmacy's. directions for storage, use, and disposal. B. EXPIRATION DATES: Unopened vials expire on the manufacturer's expiration date. Opening a vial triggers a shortened expiration date that is unique for that period. The date opened and this triggered expiration expiration date are both important to be recorded on multi-dose vials (on	F 431	affected by this issue. 3. Licensed nursing staff will be educated on policy and procedure related to labeling multi-dose medications after being opened by DON or designee. 4. Multi-dose vial medications will be observed by unit managers weekly. Observation will also be done on risk rounds twice weekly x 5 weeks, weekly x 1 month, and monthly x 3 months for documented open dates by DON or designee with audit results reported in QA meeting monthly. 5. Compliance by 11/18/16	

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F 431	Continued From page 33 the vial label or an accessory label affixed for that purpose). At a minimum, the date opened must be recorded. The above finding was shared with the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Regional Reimbursement Specialist, during the pre-exit meeting conducted on 10/14/16 at 12:15 p.m.	F 431		
F 465 SS=D	SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON CFR(s): 483.70(h) The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and facility documentation review, the facility staff failed to maintain kitchen equipment and environment in a safe, functional, and sanitary manner. The facility staff failed to maintain kitchen equipment (walk-in freezer floor and door) and environment (floors, under counter tops, and on top of dishwashing chemical container) in a safe, functional, and sanitary manner. The findings included: During the initial kitchen inspection on 10/11/16 at approximately 6:20 p.m. with the Assistant Director of Dietary, the walk-in freezer was observed to have a sheet of ice on the floor. Also,	F 465	F-465 1. Ice was immediately broken up and cleared at walk in freezer. Kitchen floors cleaned to ensure clean environment. 2. All residents are at risk for these issues. 3. A cleaning schedule will be developed by the Dietary Manager, to include specific actions and assignment. Thorough clean/scrub of floors will be scheduled 2x/month. All cleaning duties are now posted and logged for cleaning schedule. Dietary Manager will retain on file documentation of cleaning. 4. Inspections by the City of Norfolk and bi-weekly inspections of the kitchen by the Dietician will be done. Dietary Manager will be performing weekly checks of the	11/18/16

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F 465	Continued From page 34 the walk-in freezer door could not close completely because of the built up of ice around the door frame. The temperature on the outside of the walk-in freezer was 2 degrees and on the inside of the walk-in freezer the temperature was -5 degrees. Staff workers were walking in and out of the freezer at the time. A written sign was posted on the outside of the walk-in freezer. The sign read: "Keep freezer door closed tight at all times." In addition, on the initial kitchen inspection the floors were observed to be dirty with grit throughout the kitchen, along the corners and edges of the wall. The floor under the counter top where the ice machine drained was observed with white build up. During the initial kitchen inspection it was observed that the chemical sanitizer container had dirty dripping water from the wash table on it. Also, a dirty puddle formed on the entire surface of the 5 gallon container. The 5 gallon (brand name) Sanitizer was connected from the top of the container with tubing to the dishwasher. This chemical sanitizer was used to clean the dishes. On 10/12/16 at 11:15 a.m. the same observations were observed. The walk-in freezer had ice on the floor on the back portion of the freezer, in the corners and edges on the back wall. The ice build up around the freezer door remained but the door was able to close. The kitchen floors were dirty with grit and the build up under the counter remained near the airgap drain. The 5 gallon container of sanitizer had been moved under the table to prevent dirty water from dropping onto it but the lid remained dirty.	F 465	dry storage area, reach-in refrigerator, walk-in refrigerator, and walk-in freezer randomly throughout the week. Kitchen supervisor will perform daily checks throughout the week as well. Audits of food storage areas, walk-in refrigerator, walk-in freezer, meal prep areas and dish room by Dietary Manager daily. All audit results will be shared monthly at QA. 5. Compliance by 11/18/16.	

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Daily Freezer Temperature Logs were reviewed. The temperatures logged for the month of October 2016 from the first through the survey date were safe for both the refrigerator and the freezer. The only date missing a temperature reading was 10/8/16 on the p.m. shift. This was the date that the power outage occurred and it was not recorded.

The Cleaning Freezer worksheet last revised on April 2004 was provided but no had documentation to identify dates of cleaning services. This document outlined the steps to cleaning the freezer.
There was no documentation of when the freezer floor or door, the kitchen floor, or under the counters were cleaned last.

In an interview on 10/11/16 at approximately 6:30 p.m. the Assistant Director of Dietary (Others #8) stated, "The walk-in freezer floor recently flooded." In regards to the freezer door not closing he stated, "It's because of the ice build up and we check it every two weeks." Others #8 also moved the chemical sanitizer container under the table to prevent dirty water from dripping onto it.

In an interview on 10/11/16 at 7:30 p.m. the Director of the Dietary stated, "When the power went out [on 10/8/16] nothing went bad in the freezer" and "I checked the food on Sunday [10/9/16] morning." He explained, "Prior to the storm there was no water on the floor" and "I broke up as much as I could this morning with a hammer as I discovered it at 6:30 a.m." [10/11/16]. In regards to the freezer door he stated, "the door was probably left opened." Finally, he stated, "I did not discover why the water was there."

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According to the Maintenance Director in an interview on 10/12/16 at 12: 07 p.m., "The flood came from the back of the building and soaked through the concrete and come into the freezer." He also stated, "I checked caulking and cracks and sealer."

On 10/13/16 at 5:10 p.m. a housekeeping staff member (Others #7) was cleaning floors in hallway and stated, "It [the kitchen floor] needs to be done [cleaned]". He also stated, "I am not sure who is suppose to clean it. I was never told to clean it."

According to the Director of the Kitchen on 10/14/16 at 11:35 a.m., "The kitchen staff are in charge of cleaning". When asked about the process he stated, "We clean twice a month but we need deep cleaning which requires special tools-power wash." There was no evidence provided that cleaning had occurred and when. The documents provided by the director included: A list of cleaning duties (sweep mop entire kitchen) that only had days of the week, not dates of actual cleaning completed. He mentioned a kitchen staff member (Others #6) that was assigned to clean.

In an interview with Others #6 on 10/14/16 at 11:45 a.m. he stated, "I cleaned the bucket [the chemical sanitizer container] yesterday" and "yes, there was a dirty puddle on it." He added, "I also clean the freezer door once a week and the freezer floor." There was no documentation of when the freezer floor or door was cleaned last.

The Walk-in Freezer Manufacturer Maintenance Recommendation was provided by the

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Maintenance Director as the standard for maintaining the walk-in freezer. This document read, "Floors must be keep dry and clean at all times". Another warning was documented and read, "Never flush the walk-in with water...panel gaskets are designed to provide an air tight seal and do not prevent liquid or moisture from penetrating the panel joints and insulation. Excessive water may damage the panels or create a hazardous situation." Additionally, under the heading titled "General Cleaning" the document reads: "Liquid passing through the panels may collect...Standing fluids may create bacteria which could become a hazardous health condition if left unattended." Finally, the document reads, "Cleaning of the walk-in on a regular basis helps in limiting of bacterial growth" and "door should be cleaned on a regular basis as well."

The Administrator was asked for any polices regarding maintaining the kitchen and environment in a safe, functional, and sanitary manner. No policies were found or submitted.

The facility administration was informed of the findings during a briefing on 10/14/16 at approximately 12:20 p.m. The facility did not present any further information about the findings.